FOR REVIEW AND DISCUSSION

# On Common Ground for Health

Our Coordinated Efforts to Prevent and Manage Chronic Disease in Missouri

2012 - 2014

Developed by the multi-stakeholder Chronic Disease State Plan Workgroup, *On Common Ground for Health* describes recommended strategies to coordinate the prevention and management of common chronic conditions in Missouri.

Consultant Report - July 2012

## About the Planning Process

In January 2012, the Missouri Department of Health and Senior Services (DHSS) launched a planning process to enhance coordination of chronic disease prevention and health promotion activities statewide. Members of the multi-stakeholder Chronic Disease State Plan Workgroup participated in multiple discussions to recommend strategies that could build a statewide infrastructure for interventions and policies to achieve measureable improvements across the leading chronic diseases – arthritis, asthma, cancer, diabetes, heart disease, and stroke. Aligned with analysis from the Institute of Medicine* and advice from the US Centers for Disease Control and Prevention, the Workgroup was guided by two simple principles – (1) support people to live well, regardless of their chronic illness or current state of health and (2) dissolve boundaries between categorical (aka, condition-specific) program activities. Informed by surveillance data, the Workgroup built this plan from a foundation of prior work led by DHSS over the past three years, including *Integrated Chronic Disease Prevention & Management: Framework for Strategic Planning*.

***Five Strategy Areas:***

(1) planning

(2) environmental factors

(3) community linkages

(4) health care quality

(5) surveillance and evaluation

## Strategy Recommendations

A total of 11 key strategies were developed within 5 broad areas: (1) planning, (2) environmental factors, (3) community linkages, (4) health care quality, and (5) surveillance and evaluation. The Workgroup ultimately selected progress indicators under each strategy to guide statewide activity through 2014.
The indicators are specific, measureable items that, when accomplished, would ***advance Missouri's capabilities to implement an efficient, coordinated, public health approach to chronic disease.***

* National Academy of Sciences, *Living Well with Chronic Illness: A Call for Public Health Action*. 2012. www.iom.edu/livingwell

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## STRATEGY AREA #1
# Planning

Assure priorities for population-based health improvement are focused on equity among diverse socio-economic groups.

### Strategies

#### 1.1 Communication.

Establish centralized communication channels for information about chronic disease prevention and management among stakeholders statewide.

*Rationale: Successful coordination and collaboration requires responsive and proactive information-sharing. Open communication also helps establish and maintain trust among stakeholders.*

### *Progress Indicators*

- Develop common contact database of stakeholders from categorical programs (by Dec 2012)
- Develop and begin implementation of social networking strategy to link stakeholders (by Dec 2013)
- Increase number of stakeholders linked through social network tools (by Dec 2014)

#### 1.2 Leadership.

Establish coordination among partners to inform and guide evidence-based planning for chronic disease prevention and management.

*Rationale: A forum for public health experts to discuss and develop ideas can facilitate collaboration, leverage resources, and promote strategies that meet the health needs of Missourians.*

- Establish a chronic disease coordinating council drawn from existing partnerships (by Dec 2013)
- Develop and implement method for routine collection of input from diverse people with chronic disease to inform community health improvement efforts (by Dec 2012)
- Publish menu of evidence-based interventions for communities to use for local planning (by Dec 2013)

STRATEGY AREA #2

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# Environmental Factors

Promote physical activity, healthy eating, and tobacco free living by modifying influential environmental factors.

## Strategies

### 2.1 Worksite Wellness.

Build capacity among employers to adopt wellness programs targeting healthy eating, physical activity and tobacco free living.

*Rationale: Working adults with or at risk for chronic disease spend many hours per day at their jobs. Employers can influence health behaviors through wellness programs, educational campaigns, and incentives as well as health insurance benefits.*

### 2.2 Activate Change Agents.

Activate individuals and organizations to change environmental factors associated with physical activity, healthy eating, and tobacco free living.

*Rationale: A public that is engaged in and educated about public health can make informed decisions about community-wide efforts to improve health.*

## *Progress Indicators*

- Assemble stakeholders from at least 3 categorical programs to develop coordinated worksite strategy (by Dec 2013)
- Complete baseline assessment of wellness programs offered by representative sample of employers in the state (by Dec 2014)
- Launch website with health education and other tools for human resource professionals to use for wellness program development and implementation (by Dec 2014)
- Offer training program for employers that are increasing investment in worksite wellness programs (by Dec 2014)
- Increase use of key messages and materials that inform public about the association between environmental factors and physical activity, healthy eating, and tobacco free living (by Dec 2014)
- Increase number of municipalities adopting comprehensive smoke-free ordinances (by Dec 2014)
- Increase number of communities in the state that adopt ordinances or policies for safe alternate transportation modes (by Dec 2014)
- Increase percentage of adults who report healthy foods are easy to purchase in their neighborhood (by Dec 2014)

STRATEGY AREA #3

# 3 Community Linkages

Link individuals to community resources that support their personal efforts to reach optimal health.

## Strategies

### 3.1 Referral.

Implement systems to drive referrals into chronic disease prevention and management interventions.

*Rationale: Individuals and organizations that care for people with chronic conditions lack tools to coordinate referral and follow-up with specialized support program providers.*

### *Progress Indicators*

- Increase referrals from medical care providers to behavioral support programs for chronic disease self-management, weight reduction, and tobacco use cessation (by Dec 2014)
- Increase number of chronic disease prevention and management services available at the community-level (by Dec 2014)

### 3.2 Resource Awareness.

Provide public access to tailored information about community-based resources for prevention and self-management education.

*Rationale: Low awareness contributes to under-utilization of community-based prevention and self-management programs.*

- Identify organizations in all counties that can serve as a key contact for community-based resources for prevention and self-management education (by Dec 2013)
- Develop framework and manual for local public health agencies to inventory, categorize and promote community-based resources for prevention and self-management education (by Dec 2013)
- Convene task force of stakeholders to create conceptual design and basic specifications for web-based tool for accessing community-specific resources (by Dec 2014)

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## STRATEGY AREA #4
# Health Care Quality

Enhance health care system capacity to deliver coordinated, proactive, and equitable services for people with chronic conditions.

### Strategies

**4.1 Enhancing EMR Usability.**
Facilitate use of quality improvement methodologies and population management functions (e.g., registries) through efficient use of electronic medical record (EMR) systems.

*Rationale: The electronic medical record (EMR) has become part of standard practice in most primary care settings. It holds a widely untapped potential for data reporting and management which can drive improvements in quality and population health.*

### *Progress Indicators*

- Develop and begin implementation of an annual assessment of leading health care providers' use of electronic population health management tools for improving chronic care (by Dec 2013)
- Develop and publish analysis of payer policies for chronic disease prevention and management services (by Dec 2013)
- Form a team to provide technical assistance for supporting health care provider quality improvement efforts (by Dec 2013)

**4.2 Understanding Quality Metrics.**
Inform public about quality performance metrics of health care providers in chronic disease management, including patient-centered models of care.

*Rationale: Quality is a complex construct, but advances are being made to measure health care provider performance. In this era of consumer-driven health care, the public is seeking reliable information on how to assess quality and different models of care, especially for chronic conditions that require frequent interaction with the health care system.*

- Release publication (e.g., brochure, website) to educate the public about attributes and benefits of patient-centered models of care (by June 2013)
- Create inventory of quality assessment and measurement projects underway in the state (by Dec 2013)
- Develop system for directing consumers to public information about health care provider quality (by Dec 2014)

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## STRATEGY AREA #5
# Surveillance and Evaluation

Enhance utilization of surveillance data for guiding chronic disease and health promotion program planning and evaluation among state and local partners.

### Strategies

**5.1 Reporting.**
Document the burden of chronic disease across the state.

*Rationale: Stakeholders and decision-makers need valid and reliable information to guide planning, set priorities and assess change.*

**5.2 Dissemination.**
Enhance avenues for making chronic disease and health promotion data available for diverse audiences through multiple mediums.

*Rationale: Objective data can influence awareness, attitudes and public health planning only when it is accessible. The internet and social media are changing public expectations about the accessibility of health data.*

**5.3 Training.**
Provide training and technical assistance for interpretation and utilization of data in program planning and evaluation

*Rationale: The skills for accessing and interpreting health data are teachable.*

### *Progress Indicators*

- Complete comprehensive chronic disease burden report documenting trends and disparities in diseases, conditions, risk behaviors, medical care, and self-management (by Dec 2012)
- Complete a report documenting people living with multiple chronic diseases, having shared risk factors and related disparities (by June 2013)
- Assess current DHSS data dissemination systems (e.g., MICA, Profiles) for effectiveness of access and utilization by end users (by Dec 2012)
- Propose improvements to current DHSS data dissemination systems (by Dec 2013)
- Explore the potential of making data available through new avenues such as social media (by June 2013)
- Conduct hands-on training for state and local partners to increase utilization of DHSS data dissemination systems (by Dec 2013)
- Conduct training programs for state and local partners in data interpretation and utilization to improve program planning and evaluation (by Dec 2013)

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# Next Steps

*On Common Ground for Health* is an important step toward the creation of a comprehensive plan that unifies categorical (aka, condition-specific) program activities under a common framework with inter-related goals. The following steps are recommended next:

1. **Share Widely.** Using a variety of forums, present the recommended strategies in *On Common Ground for Health* to key stakeholders (e.g., local public health agency staff, community health organization leadership, health care system executives, categorical program advisory boards). The benefits of chronic disease resource coordination at state and local levels should also be described in the presentation. Compile feedback into a brief report.

2. **Align Partnerships.** Meet with partners across the state to learn how their work will be contributing to the plan's success. Work with them to identify opportunities in which their work can be aligned with 1 or 2 of the recommended strategies.

3. **Workplan.** Develop a workplan, including activities, timeline, leadership assignments, and performance measures so progress on all recommended strategies can be achieved by Dec 2014.

4. **Expand the Plan.** Create and publish an expanded version of *On Common Ground for Health* which incorporates strategies and goals specific to each of the categorical programs.

5. **Revisit and Revise.** Reconvene the Workgroup in July 2013 to assess progress and consider revising or re-prioritizing the strategies based on successes, challenges and available resources at that time.